Edison Medical Associates, LLC

Medical History

Date: / /

Name ______________________ Age ________ Birthdate ___/___/___

Address ______________________ Sex: ☐ M ☐ F

______________________ Home phone ______________________

______________________ Work phone ______________________

Occupation ______________________ Emergency contact ______________________

Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name ______________________

Children's names and ages ______________________

____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

____

Past Medical History & Review of Systems

Please circle if **you** have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. ______________
50. ______________

____

Gynecologic and Obstetric History

Age at onset of periods: ____________ Frequency: ____________ Length of period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe): ____________

Leakage of urine: ☐ No ☐ Yes (Please describe): ____________

Pelvic pain: ☐ No ☐ Yes (Please describe): ____________

Abnormal discharge: ☐ No ☐ Yes (Please describe): ____________

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): ____________

Patient Name: ***Date:*** / /

Please List and Supply the Dates of:

Operations: ____________ ____________ ____________

____________ ____________ ____________

Hospitalizations other than for surgery: ____________ ____________

____________ ____________ ____________

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? ________

Other? ______ ☐ No ☐ Yes When? ________

Pneumovax immunization? ☐ No ☐ Yes When? ________

Flu immunization? ☐ No ☐ Yes When? ________

Tetanus immunization? ☐ No ☐ Yes When? ________

When was your last:

Pap smear? ________

Mammogram? ________

Breast exam? ________

Cholesterol check? ________

Stool check for blood? ________

Prostate exam? ________

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: ________		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Question			
Do you wear seatbelts?	☐ No	☐ Yes	If no, why not? ________
Do you wear a bike helmet?	☐ No	☐ Yes	☐ N/A
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? ________
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? ________
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? ________
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? ________
If there is a gun in your home, is it out of children's reach and unloaded?	☐ No	☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: ________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: ________
Do you wish to be tested for AIDS?	No	Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	No	Yes	If yes, explain: ________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	No	Yes	
Do you ever feel afraid of your partner?	No	Yes	
Do you have a "living will"?	No	Yes	
Do you have a donor card?	No	Yes	
Method of birth control?			